AMENDED IN ASSEMBLY AUGUST 17, 2004

AMENDED IN SENATE MAY 12, 2004

SENATE BILL No. 1347

Introduced by Senator Ducheny

February 18, 2004

An act to amend, repeal, and add Sections 1351.2 and 1367.01 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1347, as amended, Ducheny. Mexican health plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Director of the Department of Managed Health Care. Existing law requires a health care service plan licensed under the laws of Mexico that elects to operate a health care service plan in this state to apply for licensure and comply with certain requirements, including offering and selling in this state only employer-sponsored group plan contracts exclusively for the benefit of citizens of Mexico legally employed in this state and their dependents. Existing law also requires any health care service plan that meets specified conditions to employ or designate a medical director who holds a license to practice medicine in this state.

This bill would, until January 1, 2008, delete the requirement that a Mexican health plan provide benefits only for citizens of Mexico and their dependents and would instead ~~allow~~ *require that it provide* benefits *only* for ~~citizens of Mexico~~ *Mexican nationals* legally employed in ~~this state, citizens of the United States living in Mexico, and Mexican citizens who have become United States citizens~~ *the County of San Diego or the County of Imperial*, and their dependents.

The bill would ~~also~~, until January 1, 2008, ~~exempt~~ *require* a Mexican health plan ~~from the requirement that the plan~~ *to* employ or designate a medical director who holds a license to practice medicine in this state *or, for health care services that are to be provided or delivered wholly in Mexico, a medical director operating under the laws of Mexico*.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1351.2 of the Health and Safety Code is amended to read:

1351.2. (a) If a prepaid health plan operating lawfully under the laws of Mexico elects to operate a health care service plan in this state, the prepaid health plan shall apply for licensure as a health care service plan under this chapter by filing an application for licensure in the form prescribed by the department and verified by an authorized representative of the applicant. The prepaid health plan shall be subject to the provisions of this chapter, and the rules adopted by the director thereunder, as determined by the director to be applicable. The application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall demonstrate compliance with the following requirements:

(1) The prepaid health plan is constituted and operating lawfully under the laws of Mexico and, if required by Mexican law, is authorized as an Insurance Institution Specializing in Health by the Mexican Insurance Commission. If the Mexican Insurance Commission determines that the prepaid health plan is not required to be authorized as an Insurance Institution Specializing in Health under the laws of Mexico, the applicant shall obtain written verification from the Mexican Insurance Commission stating that the applicant is not required to be authorized as an Insurance Institution Specializing in Health in Mexico. A Mexican prepaid health plan that is not required to be an Insurance Institution Specializing in Health shall obtain written verification from the Mexican Ministry of Health that the prepaid health plan and its provider network are operating in full compliance of Mexican law.

(2) The prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the

benefit of ~~citizens of Mexico~~ *Mexican nationals* legally employed in ~~this state, citizens of the United States living in Mexico, and Mexican citizens who have become United States citizens~~ *the County of San Diego or the County of Imperial*, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The prepaid health plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars ($1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars ($1,000,000), the prepaid health plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The prepaid health plan shall also maintain a fidelity bond and a

surety bond as required by Section 1376 and the rules of the director.

(8) The prepaid health plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the director in the form and at the time and place requested by the director. Books and records shall be made available to the director no later than 24 hours from the date of the request.

(9) The prepaid health plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. The prepaid health plan shall agree to notify the director, immediately and in no case later than one business day, if it is subject to any investigation, examination, or administrative or legal action relating to the prepaid health plan or the operations of the prepaid health plan initiated by the government of Mexico or the government of any state of Mexico against the prepaid health plan or any officer, director, security holder, or contractor owning 10 percent or more of the securities of the prepaid health plan. The prepaid health plan shall agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States shall apply.

(10) The prepaid health plan agrees that disputes arising from the group contracts involving group contractholders and providers of health care services in the United States shall be subject to the jurisdiction of the courts of this state and the United States.

(11) The prepaid health plan shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act for health care services set forth in paragraph (4). For health care services that are to be provided or delivered wholly in Mexico, the prepaid health plan may employ or designate a medical director operating under the laws of Mexico.

(b) The prepaid health plan shall pay the application processing fee and other fees and assessments set forth in Section 1356. The director, by order, may designate provisions of this chapter and

rules adopted thereunder that need not be applied to a prepaid health plan licensed under the laws of Mexico when consistent with the intent and purpose of this chapter, and in the public interest.

(c) If the plan ceases to operate legally in Mexico, the director shall immediately deliver written notice to the health care service plan that it is not in compliance with the provisions of this section. If this occurs, a health care service plan shall do all of the following:

(1) Provide the director with written proof that the prepaid health plan has complied with the laws of Mexico not later than 45 days after the date the written notice is received by the health care service plan.

(2) If, by the 45th day, the health care service plan is unable to provide written confirmation that it is in full compliance with Mexican law, the director shall notify the health care service plan in writing that it is prohibited from accepting any new enrollees or subscribers. The health care service plan shall be given an additional 180 days to comply with Mexican law or to become a licensed health care service plan.

(3) If, at the end of the 180-day notice period in paragraph (2), the health care service plan has not complied with the laws of Mexico or California, the director shall issue an order that the health care service plan cease and desist operations in California.

(d) This section shall be repealed on January 1, 2008, unless a later enacted statute, that becomes effective on or before January 1, 2008, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1351.2 is added to the Health and Safety Code, to read:

1351.2. (a) If a prepaid health plan operating lawfully under the laws of Mexico elects to operate a health care service plan in this state, the prepaid health plan shall apply for licensure as a health care service plan under this chapter by filing an application for licensure in the form prescribed by the department and verified by an authorized representative of the applicant. The prepaid health plan shall be subject to the provisions of this chapter, and the rules adopted by the director thereunder, as determined by the director to be applicable. The application shall be accompanied by

the fee prescribed by subdivision (a) of Section 1356 and shall demonstrate compliance with the following requirements:

(1) The prepaid health plan is constituted and operating lawfully under the laws of Mexico and, if required by Mexican law, is authorized as an Insurance Institution Specializing in Health by the Mexican Insurance Commission. If the Mexican Insurance Commission determines that the prepaid health plan is not required to be authorized as an Insurance Institution Specializing in Health under the laws of Mexico, the applicant shall obtain written verification from the Mexican Insurance Commission stating that the applicant is not required to be authorized as an Insurance Institution Specializing in Health in Mexico. A Mexican prepaid health plan not required to be an Insurance Institution Specializing in Health shall obtain written verification from the Mexican Ministry of Health that the prepaid health plan and its provider network are operating in full compliance of Mexican law.

(2) The prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of citizens of Mexico legally employed in this state, and for the benefit of their dependents regardless of nationality, that pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico, except for the provision or delivery of those health care services set forth in subparagraphs (A) and (B) of paragraph (4).

(3) Solicitation of plan contracts in this state is made only through insurance brokers and agents licensed in this state or a third-party administrator licensed in this state, each of which is authorized to offer and sell plan group contracts.

(4) Group contracts provide, through a contract of insurance between the prepaid health plan and an insurer admitted in this state, for the reimbursement of emergency and urgent care services provided out of area as required by subdivision (h) of Section 1345.

(5) All advertising, solicitation material, disclosure statements, evidences of coverage, and contracts are in compliance with the appropriate provisions of this chapter and the rules or orders of the director. The director shall require that each of these documents contain a legend in 10-point type, in both English and Spanish, declaring that the health care service plan contract provided by the

prepaid health plan may be limited as to benefits, rights, and remedies under state and federal law.

(6) All funds received by the prepaid health plan from a subscriber are deposited in an account of a bank organized under the laws of this state or in an account of a national bank located in this state.

(7) The prepaid health plan maintains a tangible net equity as required by this chapter and the rules of the director, as calculated under United States generally accepted accounting principles, in the amount of a least one million dollars ($1,000,000). In lieu of an amount in excess of the minimum tangible net equity of one million dollars ($1,000,000), the prepaid health plan may demonstrate a reasonable acceptable alternative reimbursement arrangement that the director may in his or her discretion accept. The prepaid health plan shall also maintain a fidelity bond and a surety bond as required by Section 1376 and the rules of the director.

(8) The prepaid health plan agrees to make all of its books and records, including the books and records of health care providers in Mexico, available to the director in the form and at the time and place requested by the director. Books and records shall be made available to the director no later than 24 hours from the date of the request.

(9) The prepaid health plan files a consent to service of process with the director and agrees to be subject to the laws of this state and the United States in any investigation, examination, dispute, or other matter arising from the advertising, solicitation, or offer and sale of a plan contract, or the management or provision of health care services in this state or throughout the United States. The prepaid health plan shall agree to notify the director, immediately and in no case later than one business day, if it is subject to any investigation, examination, or administrative or legal action relating to the prepaid health plan or the operations of the prepaid health plan initiated by the government of Mexico or the government of any state of Mexico against the prepaid health plan or any officer, director, security holder, or contractor owning 10 percent or more of the securities of the prepaid health plan. The prepaid health plan shall agree that in the event of conflict of laws in any action arising out of the license, the laws of California and the United States shall apply.

(10) The prepaid health plan agrees that disputes arising from the group contracts involving group contractholders and providers of health care services in the United States shall be subject to the jurisdiction of the courts of this state and the United States.

(b) The prepaid health plan shall pay the application processing fee and other fees and assessments set forth in Section 1356. The director, by order, may designate provisions of this chapter and rules adopted thereunder that need not be applied to a prepaid health plan licensed under the laws of Mexico when consistent with the intent and purpose of this chapter, and in the public interest.

(c) If the plan ceases to operate legally in Mexico, the director shall immediately deliver written notice to the health care service plan that it is not in compliance with the provisions of this section. If this occurs, a health care service plan shall do all of the following:

(1) Provide the director with written proof that the prepaid health plan has complied with the laws of Mexico not later than 45 days after the date the written notice is received by the health care service plan.

(2) If, by the 45th day, the health care service plan is unable to provide written confirmation it is in full compliance with Mexican law, the director shall notify the health care service plan in writing that it is prohibited from accepting any new enrollees or subscribers. The health care service plan shall be given an additional 180 days to comply with Mexican law or to become a licensed health care service plan.

(3) If, at the end of the 180-day notice period in paragraph (2), the health care service plan has not complied with the laws of Mexico or California, the director shall issue an order that the health care service plan cease and desist operations in California.

(d) This section shall become operative on January 1, 2008.

SEC. 3. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with

the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered

retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the

Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

(n) This section shall be repealed on January 1, 2008, unless a later enacted statute, that becomes effective on or before January 1, 2008, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 4. Section 1367.01 is added to the Health and Safety Code, to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service

plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2),

shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan

has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that

the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall

include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

(n) This section shall become operative on January 1, 2008.

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